MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Houston NW Medical Center P.O. Box 676907 Dallas, TX 75267-6907	MDR Tracking No.: M4-04-5133-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Service Lloyds Insurance Co. c/o Harris & Harris Box 42	Date of Injury: Employer's Name: Fourth & Inches, Inc. Insurance Carrier's No.: 9606250

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/28/03	02/03/03	Inpatient Hospitalization	$33,725.85	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a Position Summary; however, they provided a letter to the Insurance Carrier that states in part, "…The attached claim is being sent to you for review and reconsideration of payment for the following reason(s): Enclosed bill is being sent in for appeal for payment our records show this bill was over 40,000.00 which should have paid at 75 percent per TWCC this is a stop loss. Please review and pay an additional amount, patient was authorized for 4 days stayed 2 more days please review to pay for the additional 2 days…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary states in part, "…Due to the mandate of the statute, the definition of the stop-loss methodology… it is CorVel's policy to audit stop-loss bills by removing the cost of carve-outs, determine if stop-loss or per diem is appropriate, and paying cost plus 10% for implantables. The implantables are not a cost that is part of the actual treatment for the length of stay. It is a durable medical item purchased by the hospital for the patient. This is clearly recognized by TWCC as the implants are one of the carve-outs according to the TWCC ACIHFG. The charges for implants should not be included in the total for billed charges when initially calculating the methodology of payment to use. Implants are reimbursed at cost plus 10% and calculated, as such, at the end of the process. Houston Northwest Medical Center was paid at the TWCC ACIHFG surgical Per Diem of $1,118 per day for six days. For the implants, ten percent of billed was reimbursed. Therefore, after further reconsideration, no additional payment will be recommended."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 6 days (consisting of 6 days for surgical); however, only 4 days were preauthorized. Accordingly, the standard per diem amount due for this admission is equal to $4,472.00 (4 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: the Requestor did not submit invoice(s) for the implantables; therefore MDR cannot determine the cost plus 10%.

The Requestor billed a total of $54,167.08; the Respondent reimbursed the healthcare provider $6,900.00. Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Marguerite Foster	03/15/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____